AMERICAN UNITED LIFE INSURANCE COMPANY® (AUL)

a OneAmerica® company

GUARANTEED INCREASE IN BENEFIT OFFER

For

Episcopal Diocese of Fort Worth dba Anglican Benefits Program

00617336-0000-000

168

Effective

09/01/2023

Under your current Voluntary Term Life Program, your eligible employees have the opportunity to increase their life insurance coverage under the Guaranteed Increase in Benefit (GIB) during each American United Life Insurance Company® (AUL) approved Scheduled Enrollment Period without Evidence of Insurability.

An eligible employee is defined in your contract as under a certain age, actively at work on the effective date of increase, has not had an Accelerated Life Benefit claim paid, has not been declined coverage due to unsatisfactory Evidence of Insurability, and whose coverage does not exceed the maximum benefit available on the plan.

The amount of the employee's GIB offer is based on the amounts listed in the Changes In Insurance section of your contract. After the GIB increase, the amount in force cannot exceed: 1) the maximum benefit as outlined on the Schedule of Benefits page of the certificate of insurance; or, 2) five times the employee's annual base salary, whichever is LESS. If the employee's benefit reduction begins prior to the maximum GIB age, the GIB increase will be based on the employee's last reduced amount. See the Schedule of Benefits for benefit reduction information.

AUL has approved an Enrollment Period from 08/01/2023 to 08/31/2023

Please have each eligible employee complete the following Employee Guaranteed Increase in Benefit form and indicate whether or not the employee would like to take advantage of the Guaranteed Increase in Benefit offer at this time. All forms must be signed and returned to AUL before 07/01/2020; otherwise, the employee's opportunity to take advantage of this offer during this Enrollment Period will be waived.

***Please submit a complete census of all covered employees to include: name, date of birth or age, gender, occupation, and salary (as outlined in the employee's certificate). This GIB increase may be delayed until a current census is received.**

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Employee Name _____

Cert No. _____ **Date of Birth**_____

			----------GIB OFFER----------	
Coverage Type	***Current Volume***	***Current Deduction***	***New Volume***	***New Deduction***
Voluntary Term Life:	$_____	$_____	$_____	$_____
Voluntary Term AD&D:	$_____	$_____	$_____	$_____
Voluntary Dependent Term Life*		$_____		$_____
Voluntary Dependent Term AD&D*		$_____		$_____

Please indicate below whether or not you would like to take advantage of the Guaranteed Increase in Benefit (GIB) at this time. The acceptance of this GIB offer is based on all conditions listed in the Guaranteed Increase in Benefit portion of the Changes In Insurance section of the contract being met.

The amount of your GIB offer is based on the amounts listed in the Guaranteed Increase in Benefit portion of the Changes In Insurance section of your certificate of insurance. After the GIB increase, the amount in force cannot exceed: 1) the maximum benefit as outlined on the Schedule of Benefits page of the certificate of insurance; or, 2) five times your annual base salary, whichever is LESS. If your benefit reduction begins prior to the maximum GIB age, the GIB increase will be based on your last reduced amount. See your Schedule of Benefits for benefit reduction information.

☐ Yes, I want to take advantage of the Guaranteed Increase in Benefit to increase my current term coverage.

☐ No, I do not want to take advantage of the Guaranteed Increase in Benefit during this Scheduled Enrollment Period. This decision will not affect my opportunity for future increases under this option

I understand that I must be Actively At Work on the date this increase is to be effective. I authorize my employer to take deductions for this increase in coverage from my earnings. I understand that I have the right to revoke this deduction authorization at any time on written notice. I understand that if my premiums are age rated, my premiums will automatically change as I attain each new age bracket, and authorize appropriate payroll deduction changes. I also understand that the limitations and exclusions as stated on my original enrollment form will apply to the above increase.

Date:_____ Signature of Employee: _____

*Must be included if dependent coverage is based on Employee volume.

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